

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of date of deceased is shown on FILM No. 106 JUL 31 1946 is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth date of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town Blum Dale
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 mo, 3 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 8 mo, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Army War College
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

ANDERSON, CARRIE

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced _____

6. (b) Name of husband or wife James C. Anderson (deceased)6. (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) October 8, 1869 1876

8. AGE: Years 69 Months 9 Days - It less than one day _____ hrs. _____ min.

9. Birthplace Washington D.C.
(Town, county, and state)10. Usual occupation housewife

11. Industry or business _____

12. Name Samuel McClosky13. Birthplace Washington, D. C.14. Maiden name Jane Murphy15. Birthplace Washington, D. C.16. Informant Gladys Cassell, DaughterAddress (Phone) Hillside 2378-W

17. Removal Date thereof July 8, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location to Washington, D. C.18. Funeral director W. W. Chambers Co.Address 517-11th St. S.E.19. July 8, 1946 Rowland S. Phillips

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-8 19 46 at 12:52 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-5-45 19 46 to 7-8 19 46and that I last saw him alive on _____ 19 _____Immediate cause of death PULMONARY TBCDURATION 12 years

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinecone M.D.Address Glenn Dale, Md. Date signed 7/8/46

RECEIVED
JUL 12 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07191

Reg. Dist. No. 230

1. PLACE OF DEATH

County Prince Georges
 City or town College Park
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

University of Maryland Infirmary
plethora of infarct

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges
 City or town College Park
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 4904 Indian Lane
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

James Vincencio Angulo

3. (b) Social Security Number

4. Sex

male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Bartha Maria Angulo6.(c) If alive, give age. 46 years

7. Birth date of deceased (mo., day, yr.)

Nov 22, 1895

8. AGE:

Years

Months

Days

If less than one day

5082

hrs.

min.

9. Birthplace

Jucosla in
(Town, county, and state)

10. Usual occupation

Boat steno

11. Industry or business

U.S. Govt.

FATHER

12. Name Juan Angulo

13. Birthplace

Jucosla in

MOTHER

14. Maiden name Martha Nahi

15. Birthplace

Jucosla in

16. Informant

Bartha Maria Angulo

Address

College Park, Md.

17. (Burial, cremation, or removal. Which?)

BurialDate thereof July 27, 1946

Cemetery or crematory

Arlington

Location

Virginia

18. Funeral director

F. Gasco's sons

Address

Hyattsville Md.19. July 28 1946

(Date rec'd by registrar)

John D. Smith

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1946 at 5:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Acute pulmonaryarteryheart failurecardiopulmonaryrenal disease

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

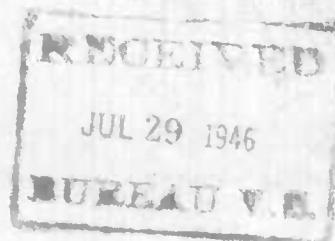
Injured at home, farm, industry, public place (where?)

Means of injury

Reputed medical examiner

23. SIGNATURE..... M. D. or other

Address Frederick Md. Date signed 7-24-46



PLEASE WRITE PLAINLY, **VOID** UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(932)

07192

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH
 County Prince Georges County
 City or town Riverdale, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Island Memorial Hosp.
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 8214 Cedar St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war no.

3. (a) FULL NAME

George Emerson Barker

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife 1st. Mrs. A. Naman Barker
2nd. Florence Seabell Koff
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb. 10, 1858
 8. AGE: Years 88 Months 5 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Esper, New York
 (Town, county, and state)
 10. Usual occupation School Teacher
 11. Industry or business _____
 12. Name Joshua Barker
 13. Birthplace New York
 14. Maiden name Emily Ingerson
 15. Birthplace New York

16. Informant Chart
 Address _____

17. Funeral Date thereof July 11, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____
 Location Lakewood Park D.C.

18. Funeral director Arthur W. Wills
 Address 284 Carroll St. N.W.

19. July 11 19 46 James Clever
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/11 19 46 at 7 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 19 46 to July 11 19 46
 and that I last saw him alive on July 10 19 46
 Immediate cause of death Congestive Heart Failure
 Due to Arteriosclerosis
Hypertension
 Due to Arteriosclerosis
Arteriosclerosis
 Other conditions _____

DURATION

36 hrs.2 yrs.2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of Injury _____ Injured at work? _____

23. SIGNATURE Rowland Wilkinson
 M. D. or other _____
 Address 4404 Greensbury Rd
Potomac, Md. Date signed 7-11-46

RECEIVED
JUL 15 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George
 City or town Middlebrook Station
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Forever
 Hospital, institution, or street address where death occurred:
On Penn R.R. Track 443 1/2 mi. N. of
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
 City or town Middlebrook Station
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Joseph Baxter

3.(b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

6.(c) If alive, give age

7. Birth date of deceased (mo., day, yr.) December 5, 1877

8. AGE:

Years

Months

Days

If less than one day

68

hrs.

min.

9. Birthplace

England

(Town, county, and state)

10. Usual occupation

Janitor

11. Industry or business

Public Schools

FATHER

12. Name

unknown

13. Birthplace

unknown

MOTHER

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Mary V. Bell

Address

Lanham, Md

17.

July 21, buried Date thereof July 21, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

St. Barnabas Cemetery

Location

Laureland

18. Funeral director

Glenn & Foreacre

Address

Mitchellville Md

19.

July 21, 1946 Louise H. Peach
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1946 at 5:22 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to 19.....

and that I last saw him..... alive on 19.....

Immediate cause of death

DURATION

Hemorrhage and shock
 Due to multiple crushing injuries to entire body
 Due to.....

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-20-46

Where did injury occur Middlebrook Station P. & M (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Railroad track

Means of injury pedestrian struck by train

deputy medical Examiner

23. SIGNATURE James J. Bond M. D. or other

Address Forestville Md Date signed 7-20-46

RECEIVED
AUG 9 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County..... Prince George's
 City or town..... Bryans Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Few days
 Hospital, institution, or street address where death occurred:
Potomac River
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince George's
 City or town..... Fort Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Veterans Administration Home
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... World War # 1 ★

3. (a) FULL NAME

Joe Beverly

3. (b) Social Security Number

223-16-8719

4. Sex..... Male 5. Color or race..... Colored 6. (a) Single, married, widowed, or divorced..... Single
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) April 1, 1897
 8. AGE: Years..... 49 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Virginia
 (Town, county, and state)
 10. Usual occupation..... Janitor
 11. Industry or business.....

FATHER 12. Name..... Unknown
 13. Birthplace..... Virginia
 MOTHER 14. Maiden name..... Unknown
 15. Birthplace..... Virginia

16. Informant..... Hospital Records
 Address..... Fort Washington, Md.

17. Burial..... Date thereof..... August 2, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Arlington National Cemetery
Arlington, Virginia
 Location.....

18. Funeral director..... Malvan & Schey
 Address..... 424 R. St. NW

19. Aug 1 19 46 Carrie Campbell
 (Date) (d by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 31 19 46 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....
 and that I last saw him..... alive on..... 19.....

Immediate cause of death..... Asphyxia
 Due to..... Drowning
 Due to.....
 Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Accident Date of.....
 Where did injury occur?..... Potomac River P. C. Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Unknown Injured at work?

Deputy Medical Examiner
 23. SIGNATURE..... James St. Louis M. or other
Frederick W. W. Date signed 8-1-46
 Address.....

RECEIVED
AUG 3 1946
BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-2

CERTIFICATE OF DEATH

07195

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince GeorgesCity or town Edmonston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs.

Hospital, institution, or street address where death occurred:

4702 Hamilton st.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pri. Geo.City or town Edmonston

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4702 Hamilton st.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

AGNES CAREY BICKERTON

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Edward Bickerton

7. Birth date of

deceased (mo., day, yr.)

Dec. 25, 1875

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

707

hrs.

min.

9. Birthplace

New Jersey

(Town, county, and state)

10. Usual occupation

Housewife.

11. Industry or business

MOTHER FATHER

12. Name

Thomas Foy

13. Birthplace

New Jersey

14. Maiden name

Maria McGonigle

15. Birthplace

Scotland

16. Informant

Ramsey Gailmard

Address

4702 Hamilton St. Edmonston, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

July 27, 1946

Cemetery or crematory

Mt. Olivet

Location

Washington, D.C.

18. Funeral director

F. Gasch's Sons

Address

Hyattsville, Md.

19. July 26

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-25-19. 46 at 8 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-1-46 19. 46 to 7-25- 19. 46and that I last saw her alive on 7-25-46 18.

Immediate cause of death

Brain tumor of

DURATION

2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

CarcinomaDate of op. 7-25-46

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Raymond K. H. H. H.

M. D. or other

Address

Hyattsville Md.

Date signed

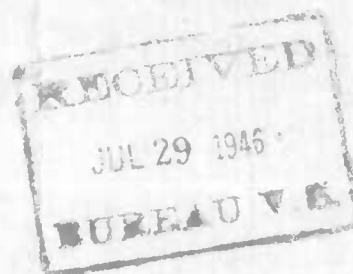
7-26-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 07195 231

1. PLACE OF DEATH:

County Prince George's CountyCity or town Chesley
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

Prince Georges Hosp.How long in hospital or institution? 10

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Pr Geo. CountyCity or town Upper Morningside
(If outside city or town limits, write RURAL and give nearest town)Street No. 328 Woodland Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mrs. Lena Black

3.(b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

B.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

now. 13-1873

8.(c) If alive, give age years

8. AGE:

Years 72

Months

Days

If less than one day

hrs. min.

9. Birthplace

Georgia
(town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Henry H. Hall

13. Birthplace

Georgia

MOTHER

14. Maiden name

Martha Leach

15. Birthplace

Germany

16. Informant

Marshall H. Black

Address

328 Woodland Dr. Upper Morningside, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jul 19 / 46
(month) (day) (year)

Cemetery or crematory

Wash Natl

Location

Smithland Md.

18. Funeral director

W. M. Chambers & Co.

Address

517-11th St. S.E.

19.

(Date rec'd by registrar)

19

7/7 46 Amanda Denny

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 7-7- 19 46 at 8:00 M

21. I CERTIFY that death occurred on the date above stated that I attended deceased from

Jul 3 19 46 to Jul 7 19 46
and that I last saw h. alive on Jul 7 19 46

Immediate cause of death

Central apoplexy

DURATION

11 days +

Due to

Hypertensive - arterio sclerotic
Heart Diseaseunknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Irvin R. Grossman

M. D. or other

Address

Mt. Rainier, Md.Date signed 7-7-46

RECEIVED

JUL 12 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

123-2

07197

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Prince GeorgesCity or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

Dr. Warren's Hosp. 307 Pr. Geo. St.How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Prince GeorgesCity or town Seabrook

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

GARRETSON BRICKERD

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Elizabeth Ellen Brickerd6.(c) If alive, give age 78 years

7. Birth date of

deceased (mo., day, yr.) June 22, 1871

8. AGE:

Years

Months

Days

If less than one day

7517

hrs. min.

9. Birthplace

Pennsylvania

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Retired

FATHER

12. Name

Israel Brickerd

13. Birthplace

Pennsylvania

MOTHER

14. Maiden name

Sydney E. Weirman

15. Birthplace

Pennsylvania

16. Informant

Walter E. Brickerd

Address

Shively, Kentucky

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 11, 1946

(month) (day) (year)

Cemetery or crematory

Perkins Chapel

Location

Springfield, Md.

18. Funeral director

F. Gasch's Sons

Address

Hyattsville, Md.19. 7-10
(Date rec'd by registrar)F. Gasch's SonsCon E. Wachter
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 11, 1946at 12:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 11, 1946 to July 11, 1946and that I last saw him alive on July 11, 1946

Immediate cause of death

Terminal Bronchitis -
Pneumonia -
Phylonephritis

DURATION

3 days
12 days

Due to

Due to

Other conditions

Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. M. Warren MD
Laurel

M. D. or other

Address

Date signed 7/9/46

RECEIVED
JUL 16 1948
BUREAU V.B.

W. B. Smith

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

07198

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
City or town (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 15 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D. C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 458 - N. Jersey Ave. S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

BROWN, BEATRICE

3. (b) Social Security Number

577-28-1554

4. Sex <u>Female</u>	5. Color or race <u>Colored</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
6. (b) Name of husband or wife _____		
7. Birth date of deceased (mo., day, yr.) <u>November 5, 1922</u>		
8. AGE: Years <u>23</u>	Months <u>8</u>	Days <u>25</u>
If less than one day hrs. min.		

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 30 1946 at 2:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1946 to July 30 1946
and that I last saw him/her alive on July 30 1946
Immediate cause of death Pulmonary Tuberculosis
DURATION 5 mos.
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace Columbia, South Carolina
(Town, county, and state)
10. Usual occupation Clerk
11. Industry or business Navy Department
12. Name Anderson, Brown
13. Birthplace South Carolina
14. Maiden name Jessie Metz
15. Birthplace South Carolina

16. Informant Decedent
Address _____
17. Removal Date thereof July 31 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Washington, D.C.
Location Kall Bros.
18. Funeral director Kall Bros.
Address 621 Florida ave., N.W., Washington D.C.
19. 7/31 46 Rowland S. Phillips
(Date rec'd by registrar) (year) Registrar

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE Daniel Leo Pinecone M.D.
Address Glenn Dale, Md. Date signed 7/30/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 5 1945

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07199

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George'sCity or town (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 months, 2 daysHospital, institution, or street address where death occurred:
Glenn Dale SanatoriumHow long in hospital or institution? 7 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. CountyCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 1436 - W. Street N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ottaway Booker Brown

3. (b) Social Security Number

579-09-8266

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Barbara F. Brown6. (c) If alive, give age 30 years7. Birth date of deceased (mo., day, yr.) February 4, 19138. AGE: Years Months Days If less than one day
33 5 24 hrs. min.9. Birthplace Amherst Co., Virginia
(Town, county, and state)10. Usual occupation Janitor

11. Industry or business

12. Name Ulysees Brown13. Birthplace Amherst Co., Virginia14. Maiden name Pearl Clark15. Birthplace Amherst Co., Virginia16. Informant DecedentAddress Removal17. (Burial, cremation, or removal, Which?) Date thereof June 29, 1946
(month) (day) (year)Cemetery or crematory WashingtonLocation D.C.18. Funeral director John J. Phillips & Co.Address 901-3rd St. S.W.19. 7/29 46 Roulaude Phillips

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1946 at 8:54 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 26, 1945 to July 28, 1946and that I last saw him alive on July 28, 1946

Immediate cause of death

Pulmonary Tuberculosis
1st Stage

DURATION

2 yrs.
23 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinucane M.D.Address Glenn Dale Md. Date signed 7/28/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 2 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age of deceased is shown

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

FILM No. I 06 JUL 17 1946

CERTIFICATE OF DEATH

★ 07200 242
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George's
City or town Lanham - Defense Highway
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's
City or town Lanham
(If outside city or town limits, write RURAL and give nearest town)
Street No. Defense Highway (Rural)
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lucy Mary C. Williams

3. (b) Social Security Number

None

4. Sex Female 5. Color or race Black 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Arthur C. Williams

6. (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Dec 16 1882

8. AGE: Years 63 5/3 5/4 Months 6 Days 19 If less than one day
..... hrs. min.

9. Birthplace Bethesda Pr Geo. Co. Md.
(Town, county, and state)

10. Usual occupation H. W.

11. Industry or business Own Home

12. Name Harley Henry

13. Birthplace Bethesda Md

14. Maiden name Williams

15. Birthplace Bethesda Md.

16. Informant Arthur C. Williams

Address Lanham Md

17. Buried Date thereof 9 July 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Catholic Church cemetery, Bowie

Location Bowie Md.

18. Funeral director E. D. Welch & Sons

Address Hunttsville Md.

19. July 9th 19 46 Mrs Jack Bennett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 19 46 at 10:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 5 19 46, to July 5 19 46

and that I last saw her alive on July 5 19 46

Immediate cause of death Chronic Myocarditis

DURATION

6 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert S. Williams, M.D.

Address 402 Main St. Laurel Md. M. D. or other

Date signed 7/6/46



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Prince GeorgesVillage or City Chesley HyattsvilleNo. Prince Georges Gen Hosp Ward

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

(a) Residence: No. _____

(Usual place of abode)

St. _____ Ward. _____

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

Willie Clark

6. DATE OF BIRTH (month, day, and year)

Aug 24 1880

7. AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or _____ min.

6566113

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)

(State or country)

PA.

MOTHER | FATHER

13. NAME

Calvin Russell

14. BIRTHPLACE (city or town)

(State or country)

PA

15. MAIDEN NAME

Polly Barrett

16. BIRTHPLACE (city or town)

(State or country)

PA

17. INFORMANT

(Address)

Mrs. Earl Rhine

18. BURIAL, CREMATION, OR REMOVAL

Place

St. Johns Chapel

Date

July 30 1946

19. UNDERTAKER

(Address)

M. F. Leaking SonsBowie

20. FILED

Date

July 29, 1946W. J. Youngling

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

July - 27 1946
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from

July 23, 1946, to July 27, 1946I last saw him alive on July 27, 1946; death is saidto have occurred on the date stated above, at 79 m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Streptococcal Rheum
General Peritonitis

Date of onset

July 22, 1946

Other Contributory Causes of importance:

Cardiac Failure
Chronic Interstitial Pneumonia

Name of operation UreteroligolDate of 7/27/46What test confirmed diagnosis? Autopsy Was there an autopsy? yes

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) W. J. Youngling(Address) Landon

M. D.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 193

CERTIFICATE OF DEATH

07202
231

Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George
 City or town Chesley
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? less than a year
 Hospital, institution, or street address where death occurred:
Prince George Inmate Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George
 City or town Newton Village
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4919 - Newton
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William E. Clemens

3. (b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>white</u>	6.(a) Single, married, widowed, or divorced <u>married</u>
6.(b) Name of husband or wife <u>Welen Lucille Clemens</u>		
6.(c) If alive, give age <u>46</u> years		
7. Birth date of deceased (mo., day, yr.) <u>March 31, 1894</u>		
8. AGE: Years <u>52</u>	Months	Days
If less than one dayhrs.min.		
9. Birthplace <u>Chicago, Ill.</u> (Town, county, and state)		
10. Usual occupation <u>mechanic</u>		
11. Industry or business		
FATHER	12. Name <u>Myrtle John Clemens</u>	
	13. Birthplace <u>Chicago, Ill.</u>	
MOTHER	14. Maiden name <u>Barbara Hammel</u>	
	15. Birthplace <u>Lebanon, Ind.</u>	
16. Informant <u>Richard William Clemens</u> Address <u>6307 Patterson St., East Riverdale</u>		
17. <u>Burial</u> (Burial, cremation, or removal. Which?) Date thereof <u>July 23 1946</u> (month) (day) (year) Cemetery or crematory <u>Fort Lincoln Cemetery</u> Location <u>Prince Georges Cty., Md.</u> <u>St. At Chambers Co.</u>		
18. Funeral director <u>St. At Chambers Co.</u> Address <u>Riverdale, Md.</u>		
19. <u>7/21</u> 19 <u>46</u> <u>Amanda Doney</u> (Date rec'd by registrar) Registrar		

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1946 at 6:25 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19....., to 19.....
 and that I last saw h..... alive on 19.....
 Immediate cause of death Shock
 Due to Electrocution
 Due to
 Other conditions
 (Include pregnancy within 8 months of death)
 Major findings of operations Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide accident Date of 7-20-46
 Where did injury occur? Newton Village, P.G. (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Home
 Means of injury Frying heater and it short circuited
Reported medical Examiner
 23. SIGNATURE James J. Boyd M.D. or other
 Address Forestville Md Date signed 7-20-46

RECEIVED
JUL 24 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07203 243

1. PLACE OF DEATH:

County Glenn Dale, Prince Georges'
City or town Glenn Dale - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D.C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 929 - French St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

George T. Coard

3. (b) Social Security Number

none

4. Sex

M

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Maud Coard

deceased

6. (c) If alive, give age

7. Birth date of

deceased (mo., day, yr.)

Dec. 25, 1889

8. AGE:

Years

Months

Days

If less than one day

56

6

8

hrs. min.

9. Birthplace

Accomac, Virginia

(Town, county, and state)

10. Usual occupation

carpenter

11. Industry or business

FATHER

12. Name

Benjamin Coard

13. Birthplace

Accomac, Virginia

MOTHER

14. Maiden name

Sarah Parker

15. Birthplace

Accomac, Virginia

16. Informant

deceased

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 6, 1946

Cemetery or crematory

Lincoln Memorial Cemetery

Location

Prince George's Co. Md.

18. Funeral director

P. S. McEneaney

Address

1820 - 9th St. N.W.

19. Date rec'd by registrar

July 3, 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 3

19 46 at 10:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 13 19 46 to July 3 19 46

and that I last saw him alive on July 3 19 46

Immediate cause of death

Pulmonary Tuberculosis

DURATION

4 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Pinucane MD

M. D. or other

Address Glenn Dale, Md. Date signed 7/3/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 12 1946
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07204

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George
City or town Hyattsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Sacred Heart Home
Stay in hospital or inst. (yrs., or mos., or days) 2 yrs 3 months
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County P.G.
City or town Hyattsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 5801 Queens Chapel Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Annie Maria Cogan

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11 1854

8. AGE: Years 92 Months Days It less than one day hrs. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business U. S. Govt.

12. Name Edward Cogan

13. Birthplace Dublin, Ireland.

14. Maiden name Ann Potts

15. Birthplace Ireland

16. Informant John J. Wilson Jr
Address 7922 Lynnbrook Drive Bethesda Md

17. Burial Date thereof July 5 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt Olivet Cemetery
Location Washington D.C.

18. Funeral director Frank Tevers Sons Co
Address 3605-14 St NW Wash. DC

19. July 2 1946 James Sever
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1946 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to July 1 1946
and that I last saw her alive on June 30 1946

Immediate cause of death
Carcinoma of Face with metastasis

DURATION
2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE James H. Collins M.D.
322 H St. N.E.
Address Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 5 1945
BUREAU V.B.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Prince George's County

Village or City Riverside Md.

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds.

Registration Dist. No. 245

No. Island Memorial St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

How long in U.S. If of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME John E. Cogswell

If U. S. Veteran, specify WAR _____

(a) Residence: No. 941-4 St. S.W. Wash D.C. Ward _____

(Usual place of abode)

If nonresident give city or town and State _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Dore Cogswell

6. DATE OF BIRTH (month, day, and year) December 27, 1860

7. AGE Years 85 Months 6 Days 13 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Owner of
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Transportation Co.
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (city or town) Alexander, Va. (State or country) _____

13. NAME John Cogswell

14. BIRTHPLACE (city or town) Va. (State or country) _____

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) _____ (State or country) _____

17. INFORMANT Frank H. Cogswell (Address) 2131-Florida Ave. N.W. Wash D.C.

18. BURIAL, CREMATION, OR REMOVAL Place Washington D.C. Date 7/10, 1946

19. UNDERTAKER P. A. Taltavull (Address) 436-7 St. S.W. Wash. D.C.

20. FILED July 10, 1946 James Bevery Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

July 10th, 1946
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 16, 1946 to July 10, 1946

I last saw him alive on July 9th, 1946; death is said to have occurred on the date stated above, at 3:21 m.

The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:

Congestive failure

Date of onset 1 week

Other Contributory Causes of Importance:

Arteriosclerotic cardiac disease

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of Injury _____, 19 _____

Where did Injury occur? _____

(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury _____

Nature of Injury _____

24. Was disease or Injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) James G. Bevery M. D.

(Address) 1212 N. Charles St. Baltimore

If more blanks are needed, address State Registrar, 2412 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE FULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 154

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mos., 14 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 2 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 127 - N. St. N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

JESSE CRAWFORD.

3. (b) Social Security Number

578-38-5185

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) March 25, 1909 6.(c) If alive, give age _____ years

8. AGE: Years 37 Months 3 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Wilson, North Carolina
 (Town, county, and state)

10. Usual occupation Shoe Finisher

11. Industry or business _____

12. Name Daniel A. Crawford

13. Birthplace North Carolina

14. Maiden name Unknown

15. Birthplace Durham, North Carolina

16. Informant Decedent

Address _____

17. Removal Date thereof July 24 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory D.C. Morgue

Location Washington, D.C.

18. Funeral director _____

Address _____

19. July 17, 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17th 19 46 at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3rd 19 46 to July 17th 19 46

and that I last saw him alive on July 17th 19 46

Immediate cause of death _____

Pulmonary Tuberculosis DURATION 3 yrs

Due to _____

Due to _____

Other conditions _____

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Leo V. Schneider M.D.

Address Glenn Dale, Md Date signed 7/17/46

MARGIN RESERVED FOR BINDING

VS A15-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 27 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4920

CERTIFICATE OF DEATH

07207

Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince Georges
 City or town Riversdale Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 days
 Hospital, institution, or street address where death occurred:
Eugene Clark Memorial Hospital
 How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Fort Ransom
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2503 Queens Chapel Rd
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Cutshaw Mrs Ethel May

3. (b) Social Security Number

4. Sex fe 5. Color or race White 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Bruce Cutshaw
 6.(c) If alive, give age 46 years
 7. Birth date of deceased (mo., day, yr.) Feb. 25 1895
 8. AGE: Years 51 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Washington, DC
 (Town, county, and state)

10. Usual occupation Chief

11. Industry or business Own home

12. Name John Henry Kettner

13. Birthplace Washington, D.C.

14. Maiden name Annied Agnes Lane

15. Birthplace Washington D.C.

16. Informant Hospital Record - Dispensary

Address taken when pt. was admitted

17. (Burial, cremation, or removal) Which? Burial Date thereof July 29 1946
 (month) (day) (year)

Cemetery or crematory Greenwood Cemetery

Location Washington DC

18. Funeral director The A. H. Jones Co.

Address 2901-14th St. N.W.

19. July 27 1946 James Sevey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27-46 1946 at 7:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1946 to July 27 1946
 and that I last saw him alive on July 27 1946

Immediate cause of death Carcinoma of ovary with General Metastases
 DURATION 1 year

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of ovary (left) Date of op. July 1946

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L.W. Malin M.D.
 M. D. or other _____

Address Riversdale Md Date signed 7-27-46

RECEIVED
JUL 29 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 07208 245

1. PLACE OF DEATH:

County Pro Geo Co
 City or town Hyattsville Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pro Geo Co.City or town Hyattsville Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5581 - 43 Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Otie Gilbert Shudrow

3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Amanda Shudrow

7. Birth date of deceased (mo., day, yr.)

Feb 9, 1870B. (c) If alive, give age 75 years

8. AGE:

Years

Months

Days

If less than one day

76

.....hrs.min.

9. Birthplace

Md. :-

(Town, county, and state)

10. Usual occupation

Struggist

11. Industry or business

FATHER

12. Name

Phillip Shudrow

13. Birthplace

unknown

MOTHER

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Address

Ralph ShudrowHyattsville Md.

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

July 6, 1946

Cemetery or crematory

Hyattstown Cemetery

Location

Hyattstown Md

18. Funeral director

Address

E. Gasch's sonsHyattsville Md.

19. (Date rec'd by registrar)

19

July 5 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 4,46

at

4 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 2 1946 to July 4 1946
 and that I last saw him alive on July 4 1946

Immediate cause of death

Coronary thrombosis

DURATION

48 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Leon and Hays

M. D. or other

Address

Hyattsville Md

Date signed

7/5/46

RECEIVED
JUL 6 1946
BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *46d*

CERTIFICATE OF DEATH

07210

Reg. Dist. No. *231*

1. PLACE OF DEATH:

County *Prince George's*
 City or town *Chesley*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *3 mo. 13 days*
 Hospital, institution, or street address where death occurred:
Prince George's General Hospital
 How long in hospital or institution? *3 mo 13 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State *Maryland* County *Prince George's*
 City or town *Bethesda*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Basil C Duvall

3. (b) Social Security Number

4. Sex *male* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) *Nov. 29 - 1884*
 8. AGE: Years *61* Months *7* Days *11* If less than one day _____ hrs. _____ min.

9. Birthplace *Maryland*
 (Town, county, and state)
 10. Usual occupation *Farmer*
 11. Industry or business _____
 12. Name *Frederick S. Duvall*
 13. Birthplace *Maryland*
 14. Maiden name *Mary Ellen Dill*
 15. Birthplace *Pennsylvania*

16. Informant *Basil E. Duvall*
 Address *Bethesda Md.*
 17. *Burial*
 (Burial, cremation, or removal. Which?) Date thereat *July 17, 1946*
 (month) (day) (year)
 Cemetery or crematory *Burtonsville Cemetery*
 Location *Burtonsville Md.*
 18. Funeral director *L. Gosch's sons*
 Address *Nyassville Md.*
 19. *7/16* *1946* *Amanda Duvall*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 15* 19 *46* at *6:10* *PM*
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *4/2* 19 *46* to *7/15* 19 *46*
 and that I last saw him *alive* on *7/15* 19 *46*
 Immediate cause of death *Cerebral Meningitis*
 DURATION *24 H*
 Due to *Culture not complete*
 Due to _____
 Other conditions *Primary carcinoma P. maxillary* *4 mo.*
Bilateral Broncho-Pneumonia *5 days*
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results *yes*
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE *Harry A. Davies MD*
 Address *1835 Eye St NW* Date signed *July 16 '46*
 M. D. or other

RECEIVED
JUL 19 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07211

Reg. Dist. No.

245

1. PLACE OF DEATH:

County Prince Georges
City or town Rivendale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hrs
Hospital, institution, or street address where death occurred:
Island Memorial Hospital
How long in hospital or institution? 12 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ohio County Selawase
City or town Sunbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. none
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Raymond E. Eckard Jr.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed or divorced Single

8. (b) Name of husband or wife new born

7. Birth date of deceased (mo., day, yr.) July 19 - 1946

8. AGE: Years 0 Months 0 Days 0 If less than one day 12 hrs. 18 min.

9. Birthplace Rivendale, Prince Georges Co. Md.
(Town, county and state)

10. Usual occupation

11. Industry or business

12. Name Raymond Walter Eckard

13. Birthplace Coburnton, Virginia

14. Maiden name Christine B. Eckard

15. Birthplace Sunbury, Ohio

16. Informant Margie Schiata

Address 4809 49th Ave Edmont, Md.

17. Burial Date thereof July 20, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evergreen Cemetery

Location Bladensburg, Md.

18. Funeral director E. Dorsch & Son

Address Hypothville, Md.

19. July 20, 1946 Jane Levy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1946 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19, 1946 to July 19, 1946

and that I last saw him/her alive on July 19, 1946

Immediate cause of death Premature Birth (3 lbs.)

DURATION 1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter H. Gibson, MD.

M. D. or other

Address 4408 - Sunbury Date signed 7/20/46

Ed Rivendale, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 26 1946

BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-2

CERTIFICATE OF DEATH

Reg. Dist. No. 07212 231

1. PLACE OF DEATH:

County Prince Georges
 City or town Kenilworth
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
1601 Eastern Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pri. Geo.
 City or town Kenilworth
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1601 Eastern Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME

EMILY GRAY

3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Charles Gray

7. Birth date of deceased (mo., day, yr.)

Feb. 16, 1860

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

86

hrs. min.

9. Birthplace

Pri. Geo. Co., Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

George Hurale

13. Birthplace

Md.

MOTHER

14. Maiden name

Unknown

15. Birthplace

16. Informant

Archie T. Gray

Address

1601 Kenilworth Av. Kenilworth, Md.

17.

Burial

Date thereof

July 27, 1946

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Ephany Episcopal

Location

Forestville, Md.

18. Funeral director

F. Gasch's Sons

Address

Hyattsville, Md.

19.

(Date rec'd by registrar)

7/26 46

Amanda H. Lowmy

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 24, 1946 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 20, 1946 to July 24, 1946

and that I last saw her alive on July 23, 1946

Immediate cause of death

Cardio-vascular Renal Disease 2 yrs.

DURATION

Due to

Due to

Other conditions

Senility

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bernard Katzen, M.D.

M. D. or other

Address

3530 Minn. Ave. S. E.

Date signed July 27, 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 27 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07213

Reg. Dist. No. 240

1. PLACE OF DEATH:

County Prince Georges
City or town Beensville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2(a) If veteran, name War.....

3. (a) FULL NAME

Walter Warren Grimes

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white widowed

6. (b) Name of husband or wife Violetta Grimes

7. Birth date of deceased (mo., day, yr.) April 19th 1881

8. AGE: Years Months Days If less than one day
75 2 16 hrs. min.

9. Birthplace Beensville, Md.
(Town, county, and state)

10. Usual occupation Blacksmith

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Ismael C. Grimes

Address Brandywine, Md.

17. Burial Date thereof July 3, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Thomas

Location Croome, Md.

18. Funeral director Ritchie Bros

Address Upper Marlboro, Md.

19. July 2 19 46 F. H. Billingsley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 19 46 at 8 A. M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from Sep. 15 19 36 to July 1st 19 46

and that I last saw him alive on May 15 19 46

Immediate cause of death mitral regurgitation DURATION 10 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John E. Bowers M. D. or other

Address Brandywine, Md. Date signed 7/1/46

MARGIN RESERVED FOR BINDING

VS-A15

9-45-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 5 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6420)

CERTIFICATE OF DEATH

Reg. Dist. No. 2032

1. PLACE OF DEATH:

County Prince GeorgesCity or town Brown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Brown
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Robert merle Hardy Jr

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Helen G. Hardy6. (c) If alive, give age 20 years

7. Birth date of deceased (mo., day, yr.)

June 19, 1922

8. AGE:

Years

Months

Days

If less than one day

2416

hrs. min.

9. Birthplace

Washington DC

(Town, county, and state)

10. Usual occupation

mechanic

11. Industry or business

M. S. Navy yardFATHER
MOTHER

12. Name

Robert merle Hardy Jr

13. Birthplace

Maryland

14. Maiden name

Hazel E. Gray

15. Birthplace

Ohio

16. Informant

Robert M. Hardy Jr

Address

9 Helens Avenue

17. (Burial, cremation, or removal, Which?)

Date thereof

July 25, 1946
(month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

Shiloh, S.W.D.

18. Funeral director

John Bros

Address

Upper Marlboro, Md.

19.

(Date read by registrar)

19.

46

46

46

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46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Heart failure and shockDue to gun shot woundof head

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 7-25-46Where did injury occur? Brown (City or town) P. G. (County) MD (State)Injured at home, farm, industry, public place (where?) in private homeMeans of injury Shot self with rifle Injured at work?Reported to medical examiner James D. Ford23. SIGNATURE Forester M. D. or otherAddress Forester Date signed 7-25-46

RECEIVED

JUL 27 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (No. 6)

CERTIFICATE OF DEATH

07215

Reg. Dist. No. 2465

1. PLACE OF DEATH:

County Prince George Co.

City or town Westmoreland, Md. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town 2001 Sun. Rd.
(If outside city or town limits, write RURAL and give nearest town)Street No. 24th Ave. N.E. D.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Roscoe Morrelle Harlan, Roscoe Morrelle

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

April 21, 1859

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

58

2

21

hrs.

min.

9. Birthplace

Dartmouth, N.H.

(Town, county, and state)

10. Usual occupation

Book - Turner

11. Industry or business

12. Name Cornelius Bern. Harlan

13. Birthplace

14. Maiden name Miss Wilson

15. Birthplace

16. Informant Sanford M. Harlan

Address 254 Westmoreland Ave. N.E. D.

17. (Burial, cremation, or removal. Which?)

Date thereof July 16, 1946

Cemetery or crematory

Location 24th Ave. N.E. D.

18. Funeral director

Address 254 Carroll St. N.E. D.

19. July 15, 1946

Louis Levy

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1946, at 10:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15, 1946, to July 14, 1946

and that I last saw him alive on July 14, 1946

Immediate cause of death

Senile weakness

DURATION

2 days

Due to

Pleurisy

2 wks.

Due to

previous lobar pneumonia with recovery (left lower)

2 mos. ago

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Silver Spring, Md. Date signed 7/14/46

RECEIVED

JUL 16 1946

BUREAU V. E.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

07216

1. PLACE OF DEATH

County Pr. Geo. Co.Registration Dist. No. 245Village or City Edgewater Md

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.2. FULL NAME Francis Harold

If U. S. Veteran, specify WAR

(a) Residence: No. 5009 46 Edgewater Md St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

colored

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

married5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE ofEphraim Harold

6. DATE OF BIRTH (month, day, and year)

Nov-7 1874

7. AGE

Years

Months

Days

If LESS than

1 day, 71 hrs.
or 7 min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.House wife9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation

12. BIRTHPLACE (city or town)

(State or country)

Prince Frederick Md

FATHER

13. NAME

Ernest Nelson

14. BIRTHPLACE (city or town)

(State or country)

Prince Frederick Md

MOTHER

15. MAIDEN NAME

Mary Bond

16. BIRTHPLACE (city or town)

(State or country)

Prince Frederick Md

17. INFORMANT

(Address)

Ernest Nelson
5009 46 Edgewater Md

18. BURIAL, CREMATION, OR REMOVAL

Place

Johns Hopkins Hosp. July 10
Baltimore Md

19. UNDERTAKER

(Address)

2053 9th St NW

20. FILED

Date

July 8, 1946

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

July
(Month)7
(Day)1946
(Year)

22.

I HEREBY CERTIFY, That I attended deceased from

June 1, 1944, to July 7, 1946I last saw him alive on July 6, 1946; death is saidto have occurred on the date stated above, at 11 p.m.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:Carcinoma of left
breast gland
metastatic in gland &
left axilla

Date of onset

1 yr3 yr

Other Contributory Causes of importance:

operated on for axillary

Name of operation

Date of 1944What test confirmed diagnosis? Carcinoma Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? no Date of injury no, 19Where did injury occur? no

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

John H. Hannon M. D.

(Address)

Hyattsville Md

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

Reg. Dist. No. 07218 237

1. PLACE OF DEATH:

County PRINCE GEORGECity or town AQUASCO
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Pg.City or town Aquasco
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Richard Hanson

3. (b) Social Security Number

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

B. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

60

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 4 19 46 at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JUNE 12 19 46 to JUNE 22 19 46and that I last saw him im alive on JUNE 22 19 46

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to ARTERIO SCLEROSISDue to CEREBROVASCULAR DISEASEOther conditions CARDIAC DECOMPENSATION

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

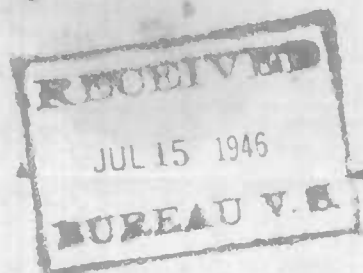
Injured at work?

23. SIGNATURE

Address

M. D.

Date signed July 5, 1946



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 142

1. PLACE OF DEATH:

County Prince Georges
 City or town Fort Washington, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month 25 days
 Hospital, institution, or street address where death occurred:
Veterans Administration Hospital
 How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 315 34th Place, N. E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War I

3. (a) FULL NAME

HATCHER, Alic T.

3. (b) Social Security Number

578-36-6701

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife None
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) July 16, 1887
 8. AGE: Years 58 Months 11 Days 23 If less than one day
 hrs. min.

9. Birthplace Lynchburg, Bedford Co., Virginia
 (Town, county, and state)

10. Usual occupation Wood Worker

11. Industry or business Self employed

12. Name Joseph Hatcher
 13. Birthplace Virginia

14. Maiden name Dora Hawkins
 15. Birthplace Virginia

16. Informant Hospital records

Address Ft. Washington, Md.

17. Burial Date thereof 7/12/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Memorial

Location Arlington, Virginia

18. Funeral director W. W. Chambers Co.

Address 517 11th St. S.E., Washington, D. C.

19. July 10 19 46 Carrie F. Campbell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 19 46 at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 14 19 46 to July 9 19 46
 and that I last saw him alive on July 9 19 46

Immediate cause of death Tuberculosis, pulmonary
 DURATION Unknown, 1-3 years

Due to.....

Due to.....

Other conditions Fracture, left radius (old)

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Ingram C. Taylor

INGRAM C. TAYLOR, M. D., Acting C.M.O.
 Address Ft. Washington, Maryland Date signed July 9, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 12 1946
BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15704

CERTIFICATE OF DEATH

07219 245
Reg. Dist. No.

1. PLACE OF DEATH: <u>Prince Georges</u> County <u>Montgomery</u> City or town <u>Takoma Park</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>2 years</u> Hospital, institution, or street address where death occurred: <u>7400 Flower Ave</u> How long in hospital or institution?	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) <u>Prince Georges</u> State <u>Maryland</u> County <u>Montgomery</u> City or town <u>Takoma Park</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>7400 Flower Ave.</u> (If rural, give LOCATION) 2.(a) If veteran, came war <u>No.</u>
---	--

3. (a) FULL NAME <u>ALICE RUTH HUFFMAN</u>	3. (b) Social Security Number <u>None</u>
---	--

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
6. (b) Name of husband or wife		
6. (c) If alive, give age <u>years</u>		
7. Birth date of deceased (mo., day, yr.) <u>June 27 1944</u>		
8. AGE:	Years <u>2</u>	Months <u>9</u>
	Days <u>9</u>	If less than one day <u>hrs. min.</u>

9. Birthplace Takoma Park, Md.
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER	12. Name <u>Thomas D. Huffman</u>
	13. Birthplace <u>West Virginia</u>
MOTHER	14. Maiden name <u>Emma A. Haas</u>
	15. Birthplace <u>Pittsburgh, Penna.</u>

16. Informant Mrs. Emma A. Huffman

Address 7400 Flower Ave. Takoma Pk, Md.

17. Removal Date thereof July 6 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington, D.C.

18. Funeral director A. A. Rines Co.

Address 2901-14th St., N.W. Wash., D.C.

19. July 6 1946 J. W. Dudley
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1946 at 11:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to July 6 1946
and that I last saw h. or alive on July 6 1946

Immediate cause of death Hydrocephalus

Due to Achondroplasia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Plautius J. L. M.D.

Address 246 Wyoming Ave N.W. Date signed July 6 1946

MARYLAND STATE DEPARTMENT OF HEALTH

AND STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

NAME

AGE

SEX

RACE

DATE

TIME

PLACE

Cause

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

RECEIVED
JUL 19 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07220245

1. PLACE OF DEATH:

County Prince George

City or town Riverdale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Leland Memorial Hospital 4408-Queensbury Rd

How long in hospital or institution? 7 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County

City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 1310-T-St., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

CHARLES M. HUNT

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Linna T. Hunt

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16th. 1878

8. AGE:

Years 67

Months 9

Days 15

If less than one day

hrs. min.

9. Birthplace Farmington, Mo.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Insurance Agent

FATHER

12. Name Louis Iris Hunt

13. Birthplace Missouri

MOTHER

14. Maiden name Martha C. Turley

15. Birthplace Missouri

16. Informant John Hunt

Address 1310-T-St., S.E.

Burial

August 5-46

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Suitland, Maryland.

18. Funeral director

Address 2007- Nichols Ave. S. E. Wash. D. C.

19. (Date rec'd by registrar)

Aug. 11 1946 James Seery

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1946 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-17-1946 to 7-31-1946

and that I last saw him alive on 7-31-1946

Immediate cause of death

Congestive Heart Failure

DURATION

3 days

Due to

Pleural effusion

5 days

Due to

Ruptured Peptic ulcer

5-7 days

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Perforated ulcer

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

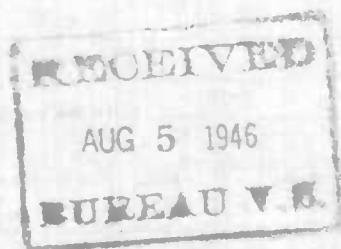
Injured at work?

23. SIGNATURE

C. L. Turley, M.D.

M.D. or other

Address 150 34602 Hope Rd. S.E. Date signed 7-31-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0722231

1. PLACE OF DEATH:

County Prince GeorgeCity or town Landover
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Landover
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

William C. Jasper

3. (b) Social Security Number

none4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Julia Warfield Jasper7. Birth date of deceased (mo., day, yr.) December 7 1859 6. (c) If alive, give age 83 years8. AGE: Years 86 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Retired Engineer11. Industry or business I.R.12. Name Josiah W. Jasper13. Birthplace Virginia14. Maiden name Elizabeth Purvis15. Birthplace Virginia16. Informant Mrs. Julia Warfield JasperAddress Landover, Md.17. Burial Date thereof July 15 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wyn Hill CemeteryLocation Alexandria, Va.18. Funeral director William Lee's Sons & Co.Address 300 - 4 St. N.E. W.C.19. 7/2 46 Armande Dinning

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 July 1946, at 9 a. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 May 1946 to 12 July 1946and that I last saw him alive on 4 July 1946Immediate cause of death Cerebral apoplexy

DURATION

3 weeksDue to generalized arteriosclerosis1 year

Due to _____

Other conditions Hypertension6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE Wm. D. Mattingly M.D. M. D. or other _____Address 2200 R. 9 Ave. NE Wash. D.C. Date signed 12 July 46

RECEIVED

JUL 15 1946

BUREAU V. S.

07222

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlen St., Baltimore (13-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mos., 19 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 2 mos., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1122- Abbey Place N. E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

JAMES E. KENNEDY JR.

3. (b) Social Security Number

577-26-0894

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

B. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) April 2, 1902 6. (c) If alive, give age _____ years

8. AGE: Years 44 Months 3 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
 (Town, county, and state)

10. Usual occupation Auto Upholsterer

11. Industry or business

12. Name James E. Kennedy
 13. Birthplace Stanton, Virginia

14. Maiden name Elizabeth Hess
 15. Birthplace Philadelphia, Pennsylvania

16. Informant Decedent

Address _____

17. Burial Date thereof July 16, 1946
 (Burial, cremation, or removal: Which?) (month) (day) (year)

Cemetery or crematory Bethel Cemetery
 Location Alexandria, Va.

18. Funeral director W. W. Chambers Co.
 Address 517-11th St. S.E., Washington D.C.

19. July 13, 1946 Rouland S. Philips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1946 at 7:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 24, 1946 to July 13, 1946 and that I last saw in alive on July 12, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 4 mo.

Due to _____

Due to Complication Tuberculosis
Saryngitis 4 mo.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Lo V. Schneider M.D.

Glenn Dale, Md. M. D. or other _____
 Address _____ Date signed 7/13/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 27 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 970

CERTIFICATE OF DEATH

Reg. Dist. No. 07223 245

1. PLACE OF DEATH:

County Pro Geo coCity or town University Park Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pro Geo coCity or town University Park Md
(If outside city or town limits, write RURAL and give nearest town)Street No. 6V-08 - 40 1/2 Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Helen M Leonard

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Harold L. Leonard

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

46

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 6, 1946 at 8:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-5-46 19, to 7-6-46 19.and that I last saw him alive on 7-6-46 19.

Immediate cause of death

Coronary occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

RECEIVED
JUL 10 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 488

CERTIFICATE OF DEATH

07224 245
Reg. Dist. No.

1. PLACE OF DEATH:

County... Prince Georges

City or town... Brinkdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4.5 min

Hospital, institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution? 4.5 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C. County...

City or town... Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 917-18th St. N. W. Wash. D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

James William Lyons

3. (b) Social Security Number

4. Sex male

5. Color or race white

6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs Gertrude Lyons

8. (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) June 1, 1871

8. AGE: Years 75 Months 1 Days 1 It less than one day hrs. min.

9. Birthplace Oxford, Butler Co., Ohio.
(Town, county, and state)

10. Usual occupation Retired post office dept employee

11. Industry or business Partner of wife at musical artists

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Mrs Gertrude Lyons

Address 917-18th St. N. W. Washington D.C.

17. Burial Date thereof July 1, 1946
(Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory St. Lincoln

Location Bladensburg Rd. & Eastern Ave.

18. Funeral director S.H. Jones Co.

Address 2901 14th St. N. W.

19. July 2 1946

(Date rec'd by registrar) Registrar James Severy

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1946, at 8:40 P.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1946, to July 1, 1946,

and that I last saw him alive on July 1, 1946.

Immediate cause of death

Terminal toxemia

I branch pneumonia

Due to carcinoma of

Stomach

Due to

Other conditions metastasis

(Include pregnancy within 2 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Cleveland W. Johnson M.D.

Address 4404 Queensbury Rd. Date signed July 2, 1946

RECEIVED

RECEIVED

RECEIVED
JUL 5 1946
RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

07225

Reg. Dist. No.

231

1. PLACE OF DEATH:

County Prince GeorgesCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Prince Georges General HospHow long in hospital or institution? 3 days

3. (a) FULL NAME

Frank McCarthy

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) Feb 17 1890

8. AGE:

Years 56 Months 5 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace

Washington D.C.
(Town, county, and state)

10. Usual occupation

Retired Plate Printer

11. Industry or business

Bu. of Eng. & Pits.

FATHER

12. Name W. H. am. R. McCarthy

13. Birthplace

D.C.

MOTHER

14. Maiden name Johnnie Sullivan

15. Birthplace

Maryland

16. Informant

James G. McCarthyAddress 4324 13th Place S.E. W.C.

17. Burial

(Burial, cremation, or removal. Which?) Burial Date thereof July 24 1946
(month) (day) (year)

Cemetery or crematory

Mt. Olivet Cemetery

Location

Washington D.C.

18. Funeral director

Robert G. Fisher

Address

641 - H. St. N.E.

19. (Date rec'd by registrar)

7/21 44 Registrar Amelia Denny

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Calverton
(If outside city or town limits, write RURAL and give nearest town)Street No. 3608 39th Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1946 at 9 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1946 to July 21 1946and that I last saw him alive on July 21 1946Immediate cause of death cerebral hemorrhageDue to hypertensionOther conditions hypertension

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE George Hapeage M.D.Address _____ Date signed 7-21-46

RECEIVED
JUL 24 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mos., 9 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 2 mos., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 112 - F. Street N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

ARMOUR MILTON McCLAY

3. (b) Social Security Number

578-18-0911

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mary A. McClay
 6.(c) If alive, give age ? years
 7. Birth date of deceased (mo., day, yr.) September 18, 1890
 8. AGE: Years 55 Months 9 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Uniontown, Pennsylvania
 (Town, county, and state)
 10. Usual occupation Carpenter
 11. Industry or business _____

FATHER 12. Name Andrew E. McClay
 13. Birthplace Uniontown, Pennsylvania
 MOTHER 14. Maiden name Nannie M. Styckle
 15. Birthplace Uniontown, Pennsylvania

16. Informant Decedent
 Address _____

17. Burial Date thereof July 5, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Washington Nat. Cemetery
 Location Prince Georges Co., Md.
W.W. Chamber Co.

18. Funeral director W.W. Chamber Co.
 Address 517-11th St. S.E. - Wash. D.C.

19. July 2, 1946 Rouland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 2 1946, at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 23 1946, to JULY 2 1946
 and that I last saw him alive on JULY 2 1946

Immediate cause of death PULMONARY TUBERCULOSIS DURATION 18 yrs. 7 mos.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured et work? _____

23. SIGNATURE Daniel Leo Finucane MD
 M. D. or other _____

Address Glenn Dale, Md. Date signed 7/2/46

RECEIVED
JUL 8 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07227 465

1. PLACE OF DEATH

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

3.(b) Social Security Number

4. Sex.....

5. Color or race.....

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

8.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

8. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

FATHER

MOTHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

18. Informant.....

Address.....

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19.

(Date rec'd by registrar)

1946

July 6

1946

James Devoy

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

July 6

1946

at

10:21

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1

1945

to

July 6

1946

and that I last saw him alive on

July 5

1946

Immediate cause of death.....

Carcinoma of prostate
Diabetes mellitus

DURATION

3 months

3 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

335- H.O.A.N.E

Date signed 7-6-46

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JUL 8 1946

BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-a)

CERTIFICATE OF DEATH

07228 231
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince GeorgesCity or town Cherryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Prince George General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State — County —City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 2515-13th St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

James John McLaughlin

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married6.(b) Name of husband or wife Ruby McLaughlin6.(c) If alive, give age 48 years7. Birth date of deceased (mo., day, yr.) July 9, 18998. AGE: Years Months Days It less than one day
47 — 1 — hrs. min.9. Birthplace Mooville, Londonderry Ireland
(Town, county, and state)10. Usual occupation Commercial Traveler11. Industry or business Industry12. Name James John McLaughlin13. Birthplace Mooville, Londonderry Ireland14. Maiden name Minnie Ruffey15. Birthplace Mooville, Londonderry Ireland16. Informant Mrs Ruby McLaughlinAddress 2515-13th N.W. Wash. D.C.17. Cremation Date thereof July 12, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort Lincoln CemeteryLocation Colmar Manor, Md.18. Funeral director J. H. Hines Co.Address 2901-14th St. N.W. Wash. D.C.19. 7/11 19 46 Amos R. Rooney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1946 at 6 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1946 to July 10, 1946and that I last saw him alive on July 10, 1946Immediate cause of death Acute myocardial infarction(2) Esophageal Varices

DURATION

10 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William Brainer M. D. registrarAddress Capitol Hotel, Md. Date signed 7/10/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 15 1946

BUREAU V B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07229

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George's
 City or town Mitchellville R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Two years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George's
 City or town Mitchellville Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D. 1.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Nannie Susan McMurtry

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife James E. McMurtry
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) March 7 1856
 8. AGE: Years 90 Months 4 Days 20 It less than one day _____ hrs. _____ min.

9. Birthplace Burhessville, Ky.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same

12. Name John A. Alexander

13. Birthplace Burhessville, Ky.

14. Maiden name Julia A. Rowland

15. Birthplace Burhessville - Ky.

16. Informant James E. McMurtry Jr.

Address Mitchellville, Md.

17. Burial Date thereof July 29 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematorium Fairfax Cemetery

Location Bowling Green, Ky.

18. Funeral director J. William Lee Sons

Address 306-4 St NE Washington DC

19. 7/28 19. 46 Amanda Daumig
 (Date rec'd by registrar) (Year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 19 46 at 2:45 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 to July 27 19 46
 and that I last saw him alive on July 26 19 46

Immediate cause of death Constrictive Heart Failure.
Nephritis
Arteriosclerosis
Secondary Anemia

DURATION 8 months
2 yrs
10 yrs
2 yrs

Due to Nephritis
Arteriosclerosis
Secondary Anemia

Other conditions Secondary Anemia
 (Include pregnancy within 3 months of death)

Major findings of operations None
 Date of op. _____

Autopsy results No
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE James C. Sancer M. D. or other
Upper Marlboro Md
 Address _____ Date signed 7-27-46

RECEIVED
JUL 30 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07230

Reg. Dist. No.

239

1. PLACE OF DEATH:

County PRINCE GEORGECity or town LAUREL
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State MARYLAND County PRINCE GEORGECity or town LAUREL Kensington
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Archibald Donald McPherson

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) SEPT 21-1936

8. AGE: Years Months Days If less than one day

991hrs.min.9. Birthplace MARYLAND

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name ARCHIBALD T. McPHERSON13. Birthplace MO.14. Maiden name MARGARET WILCOX15. Birthplace ILL.16. Informant ARCHIBALD T. McPHERSONAddress 19 CLEVELAND ST. KENSINGTON

17. Removal

(Burial, cremation, or removal. Which?) Date thereof JULY 22-46

(month) (day) (year)

Cemetery or crematory John Hopkins HospitalLocation BALTIMORE MD18. Funeral director LLOYD KAISERAddress LAUREL MD.19. Date rec'd by registrar July 22 1946Registrar Cora G. Wachtel

Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 22 1946 at 90 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-29 1946 to 7 22 1946and that I last saw him...alive on 7 22 1946Immediate cause of death Acute CardiacDilatation

DURATION

Due to myocardial infarctionDue to hypertensionOther conditions Heart failure, etc.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B P Wachtel

M. D. or other

Address Laurel MdDate signed 7 22 46

RECEIVED
JUL 30 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

07231

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George
 City or town Hyattsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo 5 da

Hospital, institution, or street address where death occurred:

Mother Jones Rest HomeHow long in hospital or institution? 1 mo 5 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MontgomeryCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)Street No. County Home
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

HERMAN

3. (b) Social Security Number

MEASER

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male white Widower

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) MAY 15-18548. AGE: Years 92 Months Days If less than one day hrs. min.9. Birthplace Baltimore Md.
(Town, county, and state)10. Usual occupation Blacksmith

11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden name unknown

15. Birthplace

16. Informant Lillie May BurgessAddress Mother Jones Rest Home
Bureau17. (Burial, cremation, or removal, Which?) Date thereof 7-13-46
(month) (day) (year)Cemetery or crematory Western buryLocation Baltimore Maryland18. Funeral director Geo. W. Wise Co. Inc.Address 2900 Mt St NW Washington DC19. July 11 46 James Sevier
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 19 46 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 5 19 46 to July 11 19 46and that I last saw him recently alive on July 11 19 46Immediate cause of death Chronic MyocarditisDue to SenilityDue to Arteriosclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lo. Allen C. GriffithAddress Berwyn MD Date signed 7/11/46

M. D. or other

RECEIVED

JUL 15 1946

BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07232

Reg. Diat. No. 243.

1. PLACE OF DEATH:

County... Prince George's
City or town... (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos., 10 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 mos., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County.....
City or town... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2268 - 6th St. N. W.
(If rural, give LOCATION)
2.(a) if veteran, name war.....

3. (a) FULL NAME

JOSEPH MELTON

3. (b) Social Security Number

-

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Mary Bishop Melton
6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) June 9, 1902

8. AGE: Years 44 Months 1 Days 10 If less than one day hrs. min.

9. Birthplace Aulander, North Carolina
(Town, county, and state)

10. Usual occupation Barber

11. Industry or business

FATHER 12. Name Josiah Melton

13. Birthplace Aulander, North Carolina

MOTHER 14. Maiden name Ada Howard

15. Birthplace Aulander, North Carolina

16. Informant Decedent

Address Remove
17. (Burial, cremation, or removal. Which?) Remove Date thereof 7/17/46
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Robert S. McQuire

Address 1820 - 9th St. N. W.

19. July 19, 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1946 at 3:25 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9, 1946 to July 19, 1946
and that I last saw him alive on July 19, 1946

Immediate cause of death

Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D.

Address Glenn Dale, Md. Date signed 7/19/46

MARGIN RESERVED FOR BINDING

943-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 27 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1600

07233

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:

County... Prince Georges
 City or town... Rindale, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 21 hrs. 50 min.
 Hospital, institution, or street address where death occurred:
 Deland Memorial Hospital
 How long in hospital or institution? 21 hrs. 50 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Prince Georges
 City or town... Landover Hills
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4209 - 71st Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

James Millios

3. (b) Social Security Number

4. Sex... Male
 5. Color or race... White
 6.(a) Single, married, widowed, or divorced... Newborn

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)... July 23, 1946
 6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
 21 hrs. 50 min.

9. Birthplace... Rindale, Md.
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name... William E. Millios

13. Birthplace... Washington D.C.

14. Maiden name... Vera Elizabeth White

15. Birthplace... Washington D.C.

16. Informant... William E. Millios - father

Address... 4209 - 71st Ave Landover Hills, Md.

17. Burial Date thereof... 24 July 46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Evergreen Cemetery

Location... Bladensburg, Md.

18. Funeral director... J. Barba Corp

Address... Hyattsville, Md.

19. July 24, 1946 James Sever

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... July 24 1946 at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 23 1946 to July 24 1946

and that I last saw him alive on July 23 1946

Immediate cause of death... Prematurity

Due to... Rupt. Membranes at 6 1/2 Mo.

Other conditions.....

Due to.....

Other conditions.....

Due to.....

Other conditions.....

Due to.....

Other conditions.....

Due to.....

Other conditions.....

Due to.....

Other conditions.....

Due to.....

Other conditions.....

Due to.....

Other conditions.....

Due to.....

Other conditions.....

Due to.....

Other conditions.....

RECEIVED
JUL 26 1946
BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

CERTIFICATE OF DEATH

07234

Reg. Dist. No. 248

1. PLACE OF DEATH:

County Prince GeorgesCity or town Edmonston
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

5205-46th Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Edmonston
(If outside city or town limits, write RURAL and give nearest town)Street No. 5205-46th Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sarah Lee Malton

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 16, 1920

6. (c) If alive, give age _____ years

8. AGE:

26

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Washington DC
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Robert Malton

13. Birthplace

North Carolina

MOTHER

14. Maiden name

Edith Irene Colston

15. Birthplace

Virginia

16. Informant

Edith Nelson

Address

5205-46 Ave

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 18 1946
(month) (day) (year)

Cemetery or crematory

Lincoln Memorial

Location

Southland Maryland

18. Funeral director

W Ernest Jarvis Co

Address

1432 8th St NW

19.

(Date read by registrar)

July 15 1946James Severy

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1946 at 8:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Acute pulmonary
edema
acute congestive
heart failure
Valvular heart
disease

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James J. Severy

(M. D. or other)

Address

Forest Hill

Date signed

7-15-46

RECEIVED

JUL 16 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07235 240
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince Georges
City or town Brandywine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME

Barbara Ann Moore

3. (b) Social Security Number

4. Sex Female 5. Color or race Col 6. (a) Single, married, widowed, or divorced single
6. (b) Name of husband or wife.....
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) October 28 - 1945
8. AGE: Years Months Days If less than one day min.
20 9 7 chaps 10 min.
9. Birthplace Brandywine, Del
(Town, county, and state)
10. Usual occupation.....

11. Industry or business.....
12. Name Joseph E. Moore
13. Birthplace Prince Georges Co. Ind
14. Maiden name Marie L. Burroughs
15. Birthplace Brandywine, Ind

16. Informant Marie L. Moore
Address Brandywine, Ind
17. Burial Date thereof July 9, 1946
(Burial, cremation, or removal. Which?) (month, day, year)
Cemetery or crematory Ashburn Cemetery
Location Near S. B. Md
18. Funeral director Huntt + Ryan
Address Waldorf, Md

19. July 8 19 46
(Date rec'd by registrar) Registrar F. H. Billingsley

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 19 46 at 4 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 46 to July 7 19 46
and that I last saw him alive on July 6 19 46
Immediate cause of death Bactrio-enteritis
DURATION 8 days
Due to.....
Due to.....
Other conditions.....

(Include pregnancy within 3 months of death)
Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John E. Powers MD
M. D. or other
Address Brandywine, Ind Date signed 7/7/46

RECEIVED
AUG. 2 1946
BUREAU V'S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

0723245
Reg. Dist. No.

1. PLACE OF DEATH: Prince George
County Prince George
City or town Mt. Rainier
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 3111 Perry street
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) 13 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Mt. Rainier Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 3111 Perry street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME
Richard Earl Morhiser

3. (b) Social Security Number _____

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife _____
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 6, 1933

8. AGE: Years 13 Months 2 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Mt. Rainier
(Town, county, and state)

10. Usual occupation Student

11. Industry or business School

FATHER 12. Name John S. Morhiser

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden name Margaret F. Moran

15. Birthplace Baltimore, Md.

16. Informant John S. Morhiser

Address 3111 Perry St., Mt. Rainier, Md.

17. Burial Date thereof 7/29/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Balto Blvd + D.C. Line

18. Funeral director Wm. J. Nalley

Address 3200 - R. Gave, Mt. Rainier

19. July 28 46 John S. Morhiser
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 19 46, at 1:30 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 15 19 46, to July 25 19 46, and that I last saw him alive on July 23 19 46.

Immediate cause of death Acute Leukemia DURATION 3 mos.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles C. Hageage M.D. M. D. or other _____

Address Mt. Rainier, Md. Date signed 7-25-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

RECEIVED

AUG 2 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134

07237

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 mo., 18 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 1 mo., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 829 - 20th St. N. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____ ✓

3. (a) FULL NAME

OPENSHAW EDITH M

3. (b) Social Security Number

-

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

8. (b) Name of husband or wife Wm. E. Openshaw

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 8, 1906

8. AGE: Years Months Days If less than one day
40 3 8 _____ hrs. _____ min.

9. Birthplace Washington, D. C.

(Town, county, and state)

10. Usual occupation Telephone Operator

11. Industry or business

FATHER 12. Name Ernest Moling
 13. Birthplace Richmond, Virginia

MOTHER 14. Maiden name Mae A. Spalding
 15. Birthplace Philadelphia, Pennsylvania

18. Informant Decedent

Address

17. Removal Date thereof July 16, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director W. W. Chambers Co.

Address

517-11-S.E.
 19. July 16, 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16- 19 46 at 8:55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-28 19 46, to 7-16 19 46

and that I last saw him alive on _____ 19 _____

Immediate cause of death

Pulmonary T.B.C.
for a long time

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

_____ Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Leo V. Schneider M.D.
Glenn Dale, Md M. D. or other
 Address _____ Date signed 7/16/46

RECEIVED
JUL 27 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170)

CERTIFICATE OF DEATH

Reg. Dist. No. 07209 245

1. PLACE OF DEATH:

County Prince George

City or town Pikesdale Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hrs. 40 min.

Hospital, institution, or street address where death occurred:

Beland Memorial Hosp.

How long in hospital or institution? 4 hrs. 40 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County P.G.

City or town Bradbury Heights
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Pendergast Mr. Douglas

3. (b) Social Security Number

4. Sex

male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 8, 1909

8. (c) If alive, give age 41 years

8. AGE:

Years 36 Months 11 Days 23 hrs. min.

9. Birthplace Hutchinson Minn.
(Town, county, and state)

10. Usual occupation Labor Foreman

11. Industry or business Anchor Fireproofing Co.

12. Name Percy Parker Pendergast

13. Birthplace Minnesota

14. Maiden name Paula Goldie

15. Birthplace Canada

18. Informant Mrs. Helen Marston Pendergast

Address 4900 S. St. 5 E. Heights, Md.

17. Burial, cremation or removal. Which? Cremation

Date thereof (month) (day) (year) July 3, 1946

Cemetery or crematory Cedar Hill

Location Suitland Md.

18. Funeral director F. Gracie, Sons

Address Syattsville Md.

July 2 A. James Sevey

19. (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1946, at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Cerebral Concussion

Due to Motor Cycle Accident

Other condition Multiple fractures

Due to Left leg

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____

Where did injury occur? _____

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury Collision with _____

Injured at work? _____

23. SIGNATURE John J. Maloney M.D.

Address _____

Date signed _____

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 5 1946

BUREAU V. A.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *servant—private family, cook—hotel, etc.* For a person who had no occupation whatever write *none*.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as “employee,” “worker,” “operative,” etc. Find out the particular kind of work done and return that, as *spinner, weaver, etc.*

In stating the industry or business, avoid the use of such general terms as “store,” “factory,” “mill,” etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill, etc.*

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer, etc.* Avoid the term “laborer” when a more precise statement of the occupation can be secured. Do not use the word “mechanic,” but give the exact occupation, as *carpenter, painter, machinist, etc.* Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a *salesman* and not a *clerk*.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1910</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on Film No. 106 - 7/24/46 is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on
 Film No. 106 - 7/24/46

MARYLAND STATE DEPARTMENT OF HEALTH
 2411 N. Charles St., Baltimore (b1)
CERTIFICATE OF DEATH

17220 230
 Reg. Dist. No.

1. PLACE OF DEATH:County Pr. GeorgesCity or town Annamdale
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Pr. GeorgesCity or town Annamdale
 (If outside city or town limits, write RURAL and give nearest town)Street No.
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAMEEmmodyns Richard**3. (b) Social Security Number**4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorcedSingle.

8. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 10th 18768. AGE: Years 69 Months 67 Days If less than one day hrs. min.9. Birthplace Ireland
 (Town, county, and state)10. Usual occupation Catholic Brother

11. Industry or business

12. Name Joseph Richards13. Birthplace Ireland14. Maiden name Bridget Brennan15. Birthplace Ireland16. Informant Brother EliasAddress Annamdale Md17. Burial Date thereof July 13th 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Annamdale MdLocation St. St. Chambers Leo18. Funeral director Riversdale MdAddress Riversdale Md19. July 13 19 46 John D Smith
 (Date rec'd by registrar) (year) Registrar**MEDICAL CERTIFICATION**20. DATE OF DEATH July 11th 19 46, at 3:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 19 19 44 to July 11 19 46and that I last saw him alive on July 11 19 46Immediate cause of death Coronary Thrombosis DURATION 1 wkDue to Arteriosclerosis 10 yrsDue to Hypertension 10 yrsOther conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE J M Warren MD M. D. or otherAddress Fairfax Date signed 7/17/46

RECEIVED

JUL 15 1946

BUREAU Y.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07240

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr., 3 mos., 23 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 1 yr., 3 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 810- 5th St. N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

RICHARD A. SAMUELS

3. (b) Social Security Number

231-12-6879

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 4, 1896
 8. AGE: Years 49 Months 9 Days 15 If less than one day _____ hrs. _____ min.

8. Birthplace Pittsylvania Co., Virginia
 (Town, county, and state)
 10. Usual occupation Sheet-metal worker
 11. Industry or business _____
 FATHER
 12. Name Archie Cabbell Samuels
 13. Birthplace Pittsylvania Co., Virginia
 MOTHER
 14. Maiden name Minnie Dodson
 15. Birthplace Pittsylvania Co., Virginia
 18. Informant Decedent

Address Removal
 17. Removal Date thereof 7/19/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory _____
 Location _____
 18. Funeral director James T. Ryan Jr.
 Address 307 Penn Ave S.E.
 19. July 19, 1946 Kowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1946 at 8:10 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 24, 1945 to July 19, 1946
 and that I last saw him alive on July 18, 1946
 Immediate cause of death Pulmonary Tuberculosis DURATION 1 yr 1 1/2 mo
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE W. V. Schneider M. D. or other _____
 Address Glenn Dale, Md Date signed 7/19/46

RECEIVED
JUL 27 1946
BUREAU V E

RECEIVED

AUG 3 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 07242 231

1. PLACE OF DEATH:

County Prince Georges
 City or town Cheverly
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince Georges General Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince GeorgesCity or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)Street No. 5308-Riverdale road.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JAMES ROBERT SMITH.

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married6. (b) Name of husband or wife Eva L.6. (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.)

June 28th 1870

8. AGE:

Years 76Months -Days 14

If less than one day

hrs. min.

9. Birthplace

Kentucky
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address 5516-Wayne - Kansas City, Mo.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof July 13th 1946
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 7/13 1946
(Date rec'd by registrar)Amanda Doney
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Fri July 12th 1946 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 19th 1945 to 7-12 1946.and that I last saw him alive on 7-12 1946.Immediate cause of death Hypertension
Cardio-Vascular-Renal
Failure

DURATION

3 years

Due to

Due to

Other conditions

Hypertension 7
Prostate
(Include pregnancy within 3 months of death)1 year

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

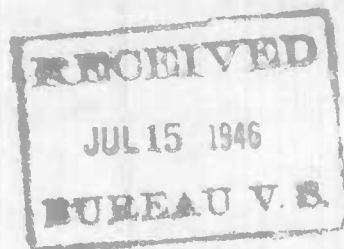
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.B. Moyer M.D.
M. D. or other
Address Int. Rainier Ind. Date signed 7-13-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of birth of deceased is shown on Film No. 106 - 7/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

2411 N. Charles St., Baltimore (77)

07243

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Geo. Co.
 City or town Riversdale, Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince Geo
 City or town Riversdale
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 6127-58th Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ella S. Southcomb

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

F W Widow

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19 - 1857 18598. AGE: Years 87 Months Days If less than one day hrs. min.9. Birthplace Dist of Columbia
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Charles T. Sardella13. Birthplace DC14. Maiden name Annie Greenains15. Birthplace Md16. Informant Annette SardellaAddress 6127-58th Ave. Riversdale, Md17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8 - 46
(month) (day) (year)Cemetery or crematory Cedar Hill CemeteryLocation West Land - Md18. Funeral director Wm Charles G.Address Riversdale, Md19. July 7 46 James Perry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 19 46 at 835 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 19 44 to July 5 19 46and that I last saw him alive on July 5 19 46Immediate cause of death ArteriosclerosisDURATION 10 yrs.Due to Insanity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE H. J. Gosson

M. D. or other

Address 3133 Com. Ave Date signed 7-6-46

RECEIVED
JUL 8 1946
BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Diat. No. 07244

1. PLACE OF DEATH:

County Prince George

City or town... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

if less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2. (a) if veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

injured at home, farm, industry, public place (where?)

Means of injury

injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07245

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs., 8 mos., 18 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 2 yrs., 8 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 220 - H. St. N. E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

THOMAS STOKES

3. (b) Social Security Number

-

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married (separated)
 6. (b) Name of husband or wife Angelina Stokes
 6. (c) If alive, give age 56 (?) years
 7. Birth date of deceased (mo., day, yr.) October 19, 1886
 8. AGE: Years 59 Months 8 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Prince Wm., Co., Virginia
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business _____
 12. Name Spencer Stokes
 13. Birthplace Plains, Virginia
 14. Maiden name Nancy Va. Hall
 15. Birthplace Virginia

16. Informant Decedent
 Address _____
 17. Removal Date thereof July 16, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory _____
 Location to Washington D.C.
 18. Funeral director Henry S. Washington & Son
 Address 467 N. St. N. W.
 19. July 15, 1946 Rowlands, Philipps
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 15 1946 at 7:40 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-27 1943 to 7-15 1946
 and that I last saw him alive on 7-15 1946

Immediate cause of death PULMONARY TUBERCULOSIS DURATION 11 yrs.
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Leo V. Schneider M.D.
Glenn Dale, Md. M. D. or other _____
 Address _____ Date signed 7-15-46

RECEIVED

JUL 27 1946

BUREAU V B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07246

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County.....
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 604 - 7th St. S. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... ✓

3. (a) FULL NAME

Eugene Joseph Tinker

3. (b) Social Security Number

578-12-9599

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) March 15, 1881 (?)
 8. AGE: Years Months Days If less than one day
65(?) 4 13 hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 28, 1946, at 3:05 P. M.
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
July 8, 1946 to July 28, 1946
 and that I last saw him alive on July 28, 1946
 Immediate cause of death.....

DURATION

5 yrs

Pulmonary Tuberculosis
 Due to.....
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

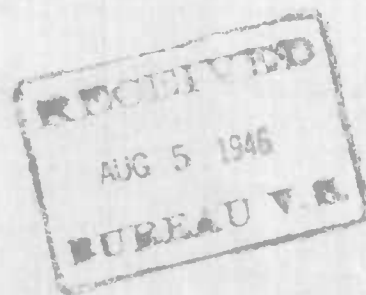
Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinecone MD
 M. D. or other
Glenn Dale, Md Date signed 7/28/46
 Address.....

9. Birthplace Washington, D. C.
 (Town, county, and state)
 10. Usual occupation Clerk
 11. Industry or business Grocery Store
 12. Name Sam Tinker
 13. Birthplace ?
 14. Maiden name Josephine Johnson
 15. Birthplace ?
 16. Informant Decedent
 Address Removal
 17. Removal Date thereof July 31, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....
 Location D. C. Morgue
 18. Funeral director Washington, D. C.
 Address 7/31 96 Rowland S. Phillips
 (Date rec'd by registrar) Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1342

CERTIFICATE OF DEATH

07247 242
★ Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George
 City or town Fort Washington, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 days
 Hospital, institution, or street address where death occurred:
Veterans Administration Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pennsylvania County _____
 City or town Philadelphia
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1715 Carlton Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War I ☒

3. (a) FULL NAME

VALENTINE, Maurice

3. (b) Social Security Number

436-10-3620

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced	
<u>Male</u>	<u>White</u>	<u>Married</u>	
6.(b) Name of husband or wife <u>Mrs. Margaret Valentine</u>			
6.(c) If alive, give age <u>46</u> years			
7. Birth date of deceased (mo., day, yr.) <u>April 18, 1890</u>			
8. AGE:	Years	Months	Days
	<u>56</u>	<u>3</u>	<u>11</u>
	If less than one dayhrs.min.		

9. Birthplace Paris, France
 (Town, county, and state)
 10. Usual occupation Cook
 11. Industry or business Merchant Marine
 12. Name Louis Valentine
 13. Birthplace France
 14. Maiden name Louise Bollin
 15. Birthplace France

16. Informant Hospital Records
 Address Fort Washington, Maryland
 17. Burial Removal Date thereof July 31, 46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Philadelphia National Cemetery
 Location Philadelphia, Pennsylvania
W. H. Chambers Co.
 18. Funeral director W. H. Chambers Co.
 Address 517 11th St., S.E., Washington, DC
July 30 19 46 Gabrie Campbell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 19 46, at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 25 19 46, to July 29 19 46
 and that I last saw him alive on July 29 19 46

Immediate cause of death Uremia DURATION 4 days

Due to Pyelonephritis, chronic 4 mos. plus

Due to _____

Other conditions Renal calculus, multiple,
left
 (Include pregnancy within 3 months of death)

Major findings of operations None
 Date of op. _____

Autopsy results Not done
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of Injury _____ Injured at work? _____

23. SIGNATURE Chas P. Benson MD
CHAS P. BENSON, MD, Acting M. D. or other
 Address Fort Washington, Maryland Date signed 7/29/46

AUG 1 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07248

Reg. Dist. No. *245*

1. PLACE OF DEATH: **Pro Geo Co**
 County.....
 City or town..... **Riverdale Md.**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **3 weeks**
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Maryland** County..... **Pro Geo Co**
 City or town..... **Greenbelt Md**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... **18 F Ridge Road**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary Voeckel

3. (b) Social Security Number

--

4. Sex..... **female**
 5. Color or race..... **white**
 6.(a) Single, married, widowed, or divorced..... **married**
 6.(b) Name of husband or wife..... **Henry Voeckel**
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... **May 10, 1886**
 8. AGE: Years..... **60** Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... **Scotland**
 (Town, county, and state)
 10. Usual occupation..... **Housewife**
 11. Industry or business.....
 12. Name..... **Edward Mc Manaman**
 13. Birthplace..... **Scotland**
 14. Maiden name..... **Mc Cormick**
 15. Birthplace..... **Scotland**

16. Informant..... **Henry Voeckel**
 Address..... **Greenbelt Md**
 17. Burial..... Date thereof..... **July 16, 1946**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Mt. Olivet Cemetery**
 Location..... **Washington D. C.**
 18. Funeral director..... **F. Gasch's Sons**
 Address..... **Hyattsville Md.**

19. **July 15** 19**46** **James Barry**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **July 13, 1946** 19..... at **2 A** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19....., to..... 19..... and that I last saw him..... alive on..... 18.....

Immediate cause of death..... **Embolic stroke following operation for varicose veins.**
 DURATION..... **1 hr.**

Due to.....
 Due to.....
 Other conditions..... **Left side paralysis due to cerebral accident**
 (Include pregnancy within 3 months of death) DURATION..... **6 mos**

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... injured at work?

23. SIGNATURE..... **John J. Maloney M.D.**
 Address..... **Chesley Md** **Chesley Dep. Md.**
 Date signed..... **7-13-46**

RECEIVED

JUL 16 1946

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73d)

07249

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George
 City or town Fort Washington, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 19 Months
 Hospital, institution, or street address where death occurred:
Veterans Administration Hospital
 How long in hospital or institution? 53 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Kansas County _____
 City or town Wichita
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1346 South Hydraulic Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War I ★

3. (a) FULL NAME

WALLACE, Robert L.

3. (b) Social Security Number

443-05-9618

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Single	
6. (b) Name of husband or wife _____			
6. (c) If alive, give age _____ years			
7. Birth date of deceased (mo., day, yr.) <u>6-29-1894</u>			
8. AGE: Years 52	Months 0	Days 11	If less than one day _____ hrs. _____ min.

9. Birthplace Maryville, Tennessee
 (Town, county, and state)
 10. Usual occupation Railroad Clerk
 11. Industry or business _____

FATHER	12. Name <u>Unknown</u>
	13. Birthplace <u>Unknown</u>
MOTHER	14. Maiden name <u>Unknown</u>
	15. Birthplace <u>Unknown</u>

16. Informant Hospital Records
 Address Fort Washington, Maryland
 17. Burial
 (Burial, cremation, or removal. Which?) Date thereof 7/13/46
 (month) (day) (year)
 Cemetery or crematory Arlington National Cemetery
Arlington, Virginia
 Location _____
 18. Funeral director W. W. Chambers Co.
 Address 517 11th St., SE, Washington, D. C.
 19. July 12 19 46 Carrie Campbell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 19 46 at 12:20 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 19 46 to July 10 19 46
 and that I last saw him alive on July 10 19 46
 Immediate cause of death Cerebral Hemorrhage
 Due to Hypertension
 Due to _____
 Other conditions Hypertensive and coronary arteriosclerotic heart disease with cardiac enlargement and intraventricular block
 (Include pregnancy within 3 months of death)
 Major findings of operations None
 Date of op. _____
 Autopsy results Not Done
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION
3 Days4 Yrs.,
Plus3 Mos.
Plus

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Ingram C. Taylor
INGRAM C. TAYLOR, M. D., Acting CMO
 Address Fort Washington, Maryland Date signed 7/10/46

RECEIVED
JUL 15 1946
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07250

Reg. Dist. No. 243

1. PLACE OF DEATH:

County P. Geo.
City or town Bowie
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: _____
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County P. Geo.
City or town Bowie Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. _____
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Dorritt E. Washington

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced _____

6. (b) Name of husband or wife

B. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 77 Months — Days — If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Retired Minister

11. Industry or business

12. Name John Washington

13. Birthplace _____

14. Maiden name _____

15. Birthplace _____

16. Informant Alice R. Hansbury

Address 1232 E. Preston St. Bto. Md.

17. Burial Date thereof July 15 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brooklyn

Location Glenn Dale P. Geo. Md.

18. Funeral director Martin Fleming Sons

Address Bowie Md.

19. July 15 19 46 Dorritt E. Washington
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 19 46 at 3:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2 19 46 to July 12 19 46, and that I last saw him alive on July 12 19 46.

Immediate cause of death Crown artery and
coronary artery heart
Due to disorder

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. H. Lancaster md

Address Bowie Date signed 7/13/46

PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

JUL 27 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 752

CERTIFICATE OF DEATH

07251

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Pro Geo co
 City or town Bladensburg Md:-
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 31 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pro Geo co
 City or town Bladensburg Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4008 - H St
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Theodore Windsor

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan 28, 1906

6.(c) If alive, give age. years

8. AGE: Years 40 Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Cemetery or crematorium

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1946 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 11, 1946 to July 16, 1946
 and that I last saw him alive on July 15, 1946

Immediate cause of death

Hypertensive Heart Disease

DURATION

6 mo

Due to

Malignant Hypertension6 mo. +

Due to

Other conditions

Old healed Osteo-sarcoma of left hip20 yrs.

(Include pregnancy within 6 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter W. Lippson, M.D.
Bladensburg, Md.

M. D. or other

Address

Date signed

7-16-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 870

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince GeorgeCity or town Systonville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 1/2 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Systonville
(If outside city or town limits, write RURAL and give nearest town)Street No. 3907 Ogletrope St.
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

BION ALBERT T. WOODLING

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Betha Lucille Woodling

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

June 20, 1916

8. AGE:

Years

Months

Days

If less than one day

7017

_____ hrs.

_____ min.

9. Birthplace

Swiftwater, Pa.
(Town, county, and state)

10. Usual occupation

Retired Railroad clerk.

11. Industry or business

FATHER

12. Name

John P. Woodling

13. Birthplace

Mt. Pocono, Pa.

MOTHER

14. Maiden name

Hannah Swan

15. Birthplace

Salem Pa.

16. Informant

Robert C. Woodling

Address

3907 Ogletrope St.17. None

(Burial, cremation, or removal. Which?)

Date thereof

July 27, 1946
(month) (day) (year)

Cemetery or crematory

Washington D.C. Scranton, Pa.

Location

18. Funeral director

L. H. Hines Co.

Address

2901-14th St. N.W. Wash. D.C.19. July 27

(Date read by registrar)

19. 46James Sevey

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1946 at 12:18 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 14 1943 to July 27 1946and that I last saw him/her alive on July 26 1946

Immediate cause of death

Myocardial failure

DURATION

1 day

Due to

Parkinsonism

10 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Hines Co.
Silver Spring, Md.

M. D. or other

Date signed 7/27/46

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

AUG 2 1946

BUREAU V C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07253

243

1. PLACE OF DEATH:

County Prince George'sCity or town (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr., 2 days

Hospital, institution, or street address where death occurred:

Glenn Dale SanatoriumHow long in hospital or institution? 1 yr., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County _____City or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 3314 - Prospect Ave. N. W.

(If rural, give LOCATION)

World War I ☒

2. (a) If veteran, name war _____

3. (a) FULL NAME

ALBERT O. WRIGHT

3. (b) Social Security Number

231-03-3300

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced6. (b) Name of husband or wife Alice Wilkins7. Birth date of deceased (mo., day, yr.) February 15, 1892
6. (c) If alive, give age ? years

8. AGE:

Years

Months

Days

If less than one day

5456

hrs.

min.

9. Birthplace Orange, Virginia
(Town, county, and state)10. Usual occupation Plasterer

11. Industry or business

12. Name Joseph L. Wright13. Birthplace Orange, Virginia14. Maiden name Martha Estes15. Birthplace Orange, Virginia16. Informant Decedent

Address

17. Removal Date thereof July 21, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Charlottesville, Virginia18. Funeral director M. C. Hill Funeral HomeAddress Charlottesville, Virginia19. July 21 19 46 Adelaide Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 21 19 46 at 7:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 19 19 45 to JULY 21 19 46and that I last saw him alive on July 21 19 46

Immediate cause of death

PULMONARY TUBERCULOSIS

DURATION

1 yr. 7 mo.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE Daniel Leo Pinckney M.D.

M. D. or other

Address Glenn Dale, Md. Date signed 7/21/46

RECEIVED

JUL 27 1946

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

117254

Reg. Diat. No.

243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr., 6 mos., 6 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 1 yr., 6 mos., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 150 Seaton Place N. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

JAMES PHELPS YOUNG

3. (b) Social Security Number

577-34-6469

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) November 11, 1926
 6. (c) If alive, give age _____ years
 8. AGE: Years 19 Months 8 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Charlotte, North Carolina
 (Town, county, and state)
 10. Usual occupation Messenger
 11. Industry or business _____

12. Name Walker C. Young
 13. Birthplace Lawrence, North Carolina
 14. Maiden name Catherine Phelps
 15. Birthplace Lawrence, North Carolina

16. Informant Decedent
 Address _____

17. removal Date thereof July 22, 1946
 (Burial, cremation, or removal. Which?) _____ month _____ (day) (year)

Cemetery or crematory _____
 Location Washington, D.C.

18. Funeral director Taylor's Funeral Home, Inc.
 Address 389 Rhode Island Ave., N.W., Wash., D.C.

19. July 22, 1946 Rowland S. Phillips
 (Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1946 19 46, at 11 P. M. 35
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15, 1945 to July 21, 1946
 and that I last saw him alive on July 21, 1946

Immediate cause of death _____ DURATION _____
Pulmonary Tuberculosis 14 yr
Total hemoptuge 6 mos.

Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Finucane MD M. D. or other _____
 Address Glenn Dale Md. Date signed 7/21/46

RECEIVED

JUL 27 1946

BUREAU V.C.